DENTAL DENTAL PLAN

of North Carolina

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Plan Document

Group #1100

This document should be read in conjunction with the **Schedule of Dental Benefit Options**. The **Schedule of Dental Benefit Options** lists the specific provisions of your Group Dental Plan. This certificate of benefits constitutes only a summary of the dental service contract. The complete contract must be consulted to determine the exact terms and conditions of coverage.

ELIGIBILITY

Covered Person: You are covered under this Program while you are a permanent eligible employee of the Group. A permanent eligible employee is one who has worked a required number of hours as established by the Group.

You may also be covered under this program if you no longer meet the above conditions and have elected Continued Coverage as described in the Continuance of Dental Care Coverage section.

Dependents: If you are enrolled for family coverage, the following dependents are covered under this Program:

a) your lawful spouse;

b) your unmarried children (including step-children, foster children and legally adopted persons) dependent on you for support and maintenance as defined in the Internal Revenue Code as outlined on the Schedule of Benefits; NOTE: dependents 19-25 must be attending college full-time.

c) any unmarried dependent child(ren) who have reached their 19th birthday, but are incapable of self-support because of physical or mental incapacity that commenced prior to their 19th birthday or the date of your eligibility in the Program.

d) any unmarried child(ren) 19 or older but under the age of 25, if such child is a high school student or a full-time student at an accredited university, college or trade school, and is chiefly dependent upon the Employee for support. Proof of full-time student status is required each semester.

Dependents in military service are not covered.

Dependents no longer meeting the above requirements because of divorce or separation from an eligible subscriber, or the cessation of the dependency status of an eligible subscriber's child may elect Continued Coverage as described in the Continuance of Dental Care Coverage section.

EFFECTIVE DATES OF COVERAGE

Covered Persons: You are covered under this program:

a) on the date this Program first became effective; or

b) on the date of enrollment following completion of any waiting periods as established by the Group.

Dependents: Your eligible dependents are covered under this Program:

a) on the date you first become covered under this Program; or

b) on the date of enrollment a new dependent is acquired. Notification must be received by the Plan Administrator within thirty (30) days of addition.

TERMINATION OF COVERAGE

Your coverage and that of your eligible dependents on the earliest of the following dates:

on the date in which 1) you cease to be eligible, 2) your dependent(s) is no longer eligible as a dependent under the Plan;

a) on the date of Program is terminated;

b) on the date the Group terminates the Contract by failure to pay the required premium.

In the event of the loss of eligibility status, both subscribers and dependents may elect to continue coverage as described in the Continuance of Dental Care Coverage section.

All benefits cease on the date coverage terminates, except for completion of operative procedures in progress at the time of termination. Operative procedures are defined as and limited to individual crowns, dentures and bridges, and are considered in progress only if all procedures for commencement of lab work have been completed and all operative procedures are

completed within sixty (60) days of termination. The benefits payable, however, are still subject to all the Conditions and Limitations of the Program.

CONTINUANCE OF DENTAL CARE COVERAGE

NOTE: Applies only to employer groups of twenty persons or more.

The Consolidated Omnibus Budget Reconciliation Act (COBRA) allows you to self-pay continued dental care coverage in certain circumstances where your coverage would otherwise end. The sections outlined below will summarize your continued dental care rights under the law.

Your dental care self-pay rights: If you lose coverage under this Program because your employment terminates (for other than gross misconduct) or because your hours are reduced, you may continue your dental care coverage under the Program for yourself, your spouse and dependent children for up to eighteen (18) months. If you choose to continue your coverage, you must pay for the full monthly cost.

If your spouse or dependent child(ren) (if any) are enrolled in this Program and lose coverage because of one of the following events, they may choose to continue dental care coverage for up to thirty-six (36) months:

a) death of employee;

b) divorce or legal separation of the employee and spouse;

c) a dependent child reaches maximum age (as defined by the Contract).

Your spouse or dependent must pay the full cost of coverage each month.

Notification process: Your employer will advise us if you lose coverage under this Program as a result of termination of employment or reduction in hours worked. Your employer will then notify you of your self-pay options and the Program's monthly costs. You will then have up to sixty (60) days to decide whether or not to purchase the coverage.

If your spouse loses coverage due to divorce or legal separation or your death, or your dependent child loses coverage because he/she has ceased to be a dependent child under the requirements of this Contract and wants to continue coverage, you or your spouse or dependent children must immediately notify the Human Resources Department at your company.

Your spouse or child will then be given information about the self-pay option and the Plan's monthly cost and will have sixty (60) days to decide about purchasing the coverage.

Termination of Continued Coverage: Your continued dental care coverage can terminate before the full eighteen (18) or thirty-six (36) months (whichever applies) if:

a) you fail to pay the required premium on time;

b) the Program terminates;

c) the person continuing coverage becomes eligible for Medicare;

d) the person continuing coverage becomes covered under another group dental plan; or

e) in the case of a spouse beneficiary, the spouse remarries and becomes covered under another group dental plan.

Conversion rights are not applicable to dental benefits.

If you have any questions about Continuance of Dental Care Benefits, contact Employee Benefits in Human Resources for the City of Asheville.

DESCRIPTION OF SERVICES

NOTE: Only those services indicated as "Covered Benefits" included in the Schedule of Dental Benefit Options are covered.

The Program covers the following services when they are performed by a licensed dentist and when necessary and customary as determined by the standards of generally accepted dental practice.

Services covered are subject to the Limitations described within each coverage and the Exclusions outlined later.

Diagnostic and preventive Services:

a) Routine periodic examinations (twice in a 12 month period)

b) Prophylaxis (teeth cleaning) (twice in a 12 month period)

c) Bitewing x-rays (once in a 12 month period)

d) Full mouth x-rays (once in a 5 year period)

e) Topical fluoride applications (dependent children to age 19)

f) Space maintainers (for premature loss of tooth)

g) Topical applications of sealants for dependents to age 16. Application is limited to the occlusal surface of permanent molars which are free of caries and restorations. Benefits are limited to one (1) application per lifetime.

h) Emergency treatment to relieve pain.

Basic and Restorative Services:

a) Oral Surgery – The necessary procedures for extractions and other oral surgery including pre- and post-operative care.

b) Restorative Dentistry – Provides amalgam, composite and plastic restorations for treatment of carious lesions. (Not more than once in a twenty-four (24) month period when applied to the same tooth surface and number.)

c) Endodontics – The necessary procedure for pulpal therapy and root canal filling (treatment of non-vital teeth).

d) Periodontics – The necessary procedures for treatment of the tissues supporting the teeth.

e) Denture Repair – The procedures necessary to repair an existing denture.

Gold and Cast Restorations: Crowns, jackets, and gold or cast restorations when teeth cannot be restored with amalgam, composite or plastic restorations. (Coverage for a crown for the purpose of replacing a prior crown will be provided only after a five (5) year period measured from the date on which the crown was last supplied.)

Prosthodontics: The necessary procedures for construction of bridges, partial and complete dentures. (Coverage for the replacement of a prosthetic appliance will be provided only after a five (5) year period measured from the date on which appliance was last supplied.

Denture reline or rebase is a benefit once in any 36 month period.

Orthodontic Services: Includes orthodontic appliances and treatment, interceptive and corrective, for all eligible dependent children to their 19th birthday. Related services for orthodontic purposes, such as exams, x-rays, extractions, space maintainers, and study models shall be paid at the orthodontic co-payment percentage. If orthodontic coverage was provided under a prepaid dental program immediately preceding this Program effective date, the Plan shall provide benefits for the unearned portion of the treatment in progress. The Plan shall be the sole determinant of this unearned amount eligible for coverage. **LIMITATION**: If the treatment plan is terminated or the patient is no longer eligible for benefits before completion of the case for any reason, the obligation of the Plan will cease with payment to the date of termination. The Plan will not make any payment for the repair or replacement of an orthodontic appliance.

PARTICIPATING DENTISTS

Under the Program, you are free to go to the dentist of your choice. If your dentist participates with the Plan, he has agreed to accept direct payment from Delta on a usual, customary and

reasonable (UCR) fee basis. You receive a Notification of Benefits form indicating the amount the Plan has paid to the participating dentist and the amount, if any, you owe the dentist.

NON-PARTICIPATING DENTISTS

If your dentist is not a participating member, the Plan will send payment for covered dental services directly to you. You are responsible for reimbursing your dentist through his usual billing procedure.

If the fee charged is not allowed in full, the Plan is not implying the dentist is overcharging. Dental fees vary and are based on the dentist's overhead, skill and experience. Therefore, not every dentist will have fees that fall within the allowable UCR fee range.

EXCLUSIONS

Coverage is NOT provided for:

a) Benefits or services for injuries or conditions compensable under Workers' Compensation or Employer's Liability Laws, or which are available from any Federal or State Government agency, municipality, county or other political subdivision or community agency.

b) Benefits or services which are determined to be partially or wholly cosmetic in nature.

c) Benefits, services or appliances, including prosthetics, started prior to the date the patient became eligible under this Program.

d) Benefits for full porcelain crowns and composite restorations in posterior teeth. The Plan will pay the applicable percentage of the fee for a cast crown or amalgam restoration.

e) Prescription drugs, pre-medications and relative analgesia, charges for hospitalization; general anesthesia for restorative dentistry; preventive control programs, charges for failure to keep a schedule visit with the dentist; services of anesthesiologist; charges for completion of forms; charges for consultation.

f) Charges for treatment of or services related to temporomandibular joint dysfunction.

g) Appliances or restorations for increasing vertical dimension; for restoring occlusion; for replacing tooth structure lost by attrition; for correcting congenital or developmental malformations, including replacement of congenitally missing teeth, for esthetic purposes; for implantology techniques; periodontal or other splints, unless necessary as a result of accidental injury.

h) Benefits for treatment by other than a dentist, except the scaling or cleaning of teeth and topical application of fluoride when performed by a licensed dental hygienist, if the

treatment is rendered under the supervision and guidance of the dentist, in accordance with generally accepted dental standards.

i) Claims not submitted to DDPNC within twelve (12) months of the date of service or as soon as is reasonably possible.

j) Treatment rendered outside of the United States or Canada.

k) Replacement of lost or stolen dentures or charges for duplicate dentures.

l) Orthodontic services and related orthodontic services, such as but not limited to, exams, x-rays, extractions and study models which are rendered solely orthodontic purposes, unless orthodontics is included as a covered benefit on the Schedule of Dental Benefit Options.

m) Extra oral grafts.

n) Crown, bridge, and denture, except as provided herein.

o) Any service which is not specifically provided under this Program or is excluded by the rules and regulations of the Plan.

p) Any service unless listed as a benefit under Schedule of Dental Benefit Options.

OPTIONAL TREATMENT

In all cases in which the patient selects a more expensive service or benefit than is needed, the Plan will pay the applicable percentage of the fee for the service or benefit which is needed to restore the tooth or dental arch to contour and function. The balance of the treatment cost shall be the responsibility of the patient.

COORDINATION OF BENEFITS

If you or your family members are eligible to receive payment of dental benefits under another group plan, benefits from this Program will be coordinated with the benefits from any other of your group plans so that up to 100% of the "allowable expenses" will be paid jointly by the plans. An "allowable expense" is any necessary, reasonable and customary item of expense covered in full or in part by this Plan.

The Coordination of Benefits provision establishes an order of benefit determination between the plans to determine which plan has the primary responsibility for providing the first payment on a claim.

When a husband and wife seek work for different firms, they may be covered under two group plans providing dental benefits. In determining the order of benefit determination, the plan

covering the patient as an employee has the primary responsibility for providing benefits before the plan covering the patient as a dependent.

If the patient is a dependent child, the plan which covers the parent whose birth date occurs earlier in the calendar year (month and day only) will be primary. The plan which covers the parent whose birth date is later in the calendar will be secondary.

In situations where a person is laid off or retires and continues to be covered under the group's plan and then secures other employment, which also provides some coverage for group dental benefits, the plan which covers the person as an active employee will be primary to the plan which covers the person as a retired or laid off employee.

However, if the other group plan does not have a Coordination of Benefits provision, the group plan has the primary responsibility for the claim.

DUAL DELTA DENTAL PLAN COVERAGE

If a patient is eligible for coverage under two or more Delta Dental Plan (DDP) Programs and more than one Program provides coverage for a particular service, neither Plan will be charged with an amount greater than the amount for which it would be liable if such dual coverage did not exist.

THE IMPORTANCE OF A PRE-STATEMENT OF COSTS

(Pre-determination of Benefits)

After an examination, your dentist will establish the treatment to be performed. If the services involve Cast Restorations, Crowns or Prosthodontics your dentist should sumbit an Attending Dentist's Statement to the Plan. The Plan will determine if the proposed treatment is covered under this Program and the amount the Plan will pay toward the cost of such treatment. The Attending Dentist's Statement will be returned to your dentist.

After discussions with your dentist, you will know the amount payable by the Plan and the amount of your obligation if the services are performed within the period of authorization (90 days from the date of the Plan's approval) as indicated to your dentist on the Attending Dentist's Statement. An Attending Dentist's Statement is filed for payment with the Plan upon completion of the services.

SETTLEMENT OF DISPUTES

In the event of a dispute between DDP and the dentist with respect to any of the terms, conditions or benefits of this Program, the facts will be presented by the Plan or the dentist, with notice given to the other party, to the local Peer Review Committee of the local dental society for adjudication by such Committee. If the Plan or the dentist is not satisfied with the judgment of the local Peer Review Committee, an appeal may be made to the State Peer Review Committee.

All disputes shall be settled in this manner before any action at law is taken by the Plan.

PLAN LIABILITY

The Plan acts only as the intermediary between dentists and the Group and subscribers. In no instance shall the Plan be liable for any conduct including but not limited to tortious conduct, negligence, wrongful acts or omissions of any person including but not limited to subscriber, dentist, dental assistant, dental hygienist, hospital or hospital employee receiving or providing services. In no instance shall the Plan be liable for services of facilities which, for any reason, are unavailable to the subscriber.

THE CITY OF ASHEVILLE

Schedule of Dental Benefit Options

		Std-Option	Hi-Option
1.	DIAGNOSTIC & PREVENTIVE		
a.	Prophylaxis (2 per year)	80%	100%
b.	Exams		
c.	X-rays		
d.	Fluoride Treatment (children only)		
2.	BASIC & RESTORATIVE	80%	80%
e.	Oral Surgery		
f.	Restorative (Fillings)		
g.	Endodontics (Root Canals)		
h.	Periodontics (Treatment of the gums)		
i.	Denture Repair		

3.	GOLD & CAST RESTORATIONS		50%	50%
	Crowns when teeth cannot be restored			
	W/amalgam, composite or plastic restorations.			
4.	PROSTHODONTICS		30%	50%
	Partial or Complete Dentures, Bridges			
	(the replacement of missing teeth)			
5.	ORTHODONTICS		N/A	50%
	Lifetime Maximum $1,000 per patient			
	Lifetime Maximum $3,000 per family			
	(Benefit for dependent children only)			
6.	DEDUCTIBLES:	Per Person	$50	$25
	per contract year	Per Family	$150	$75
	(Not applied to Diagnostic			
	& Preventive)			
7.	MAXIMUM			
	Per Calendar Year		$1,000	$1,500